

PRENATAL CARE COORDINATION POSTPARTUM / NEWBORN ASSESSMENT

NOTE: All information required for Medicaid Prenatal Outcome Report is Bold and Italicized.

AGENCY: _____ ADDRESS: _____ CONTACT PERSON: _____ PHONE: _____ FAX: _____		MCO: _____ DATE: _____ CONTACT PERSON: _____ PHONE: _____ FAX: _____ CODE: <u>99501</u> AUTHORIZATION #: _____	
Date Of Visit: _____		# WEEKS POSTPARTUM: _____	
Mother's Name: _____		Mother's Medicaid #: _____	
MARITAL STATUS AT TIME OF DELIVERY: _____		Address: _____ Phone: _____	
Infant's Name: _____		INFANT'S MEDICAID #: _____	
DOB: _____	B W: ___ LBS ___ OZ	WEEKS GESTATION: _____	# LIVE BIRTHS: _____ LIVING WITH MOTHER: Y N
CODES: X = Significant O = No Problem P = Potential N – See Note			
ASSESSMENT		CODE O/P	COMMENTS/TEACHING/HANDOUTS/REFERRALS
1. HOME ENVIRONMENT			
a) Language spoken in home			
b) NUMBER IN HOUSEHOLD, (total, <5 y, >5y)			
c) Housing adequate/safe/ good condition			
d) Cleanliness (roaches, vermin)			
e) Working utilities / Stove / Refrigerator			
f) Working Smoke Detectors			
G) SECOND HAND SMOKE EXPOSURE			
H) MOTHER SMOKES? HOW MUCH?			
i) Other			
2. BASIC CARE ITEMS			
a) Bassinet / Crib safe			
b) Diapers / clothing/ thermometer			
c) Infant Car Seat			
d) Feeding supplies			
e) Other			
3. MOTHER'S HEALTH			Mos wt at delivery _____ TOTAL WEIGHT GAIN _____
a) General Post partum Wellbeing			
b) Nutrition Intake adequate			
c) Physical activity / fatigue			
d) Emotional Status (PP Blues/Depression)			
e) PP EXAM (Date of exam)			
F) BIRTH CONTROL PLAN?			Abstinence=01 Other=02 No=03 Unknown=99
g) Other			
4. PSYCHOSOCIAL			
A) SUPPORT DURING PREGNANCY			During pregnancy did she believe support to be <input type="checkbox"/> Enough <input type="checkbox"/> Not enough <input type="checkbox"/> Too much
B) SUPPORT AT THIS TIME			At this time does she believe support to be <input type="checkbox"/> Enough <input type="checkbox"/> Not enough <input type="checkbox"/> Too much
c) Family/ Father of baby involved			
d) Domestic violence			
e) Substance Use			
1. Tobacco (amt)			
2. Alcohol/ Drugs			
3. Illicit Drugs			
4. Prescription/OTC drugs			
f) Missed appointments			
g) Barriers to care			
h) Cultural practices			
i) Plans to return to work/school			
j) Perceived Stress Level			
k) Inadeq. Income to meet basic need			
l) Moves freq. (moved since delivery)			
m) Medicaid status			
n) Adequate food supply			
o) Other			

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[illegible]

If this was a fetal or infant death complete the outcome report and the FIMR assessment report

REFERRALS/CODES CHECK all that apply			
<input type="checkbox"/> Alcohol/Drug Abuse Services	<input type="checkbox"/> First Steps	<input type="checkbox"/> Mental Health Services	<input type="checkbox"/> Social Services
<input type="checkbox"/> Adult Ed/GED	<input type="checkbox"/> Food Stamps	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Transportation
<input type="checkbox"/> Domestic Violence Program	<input type="checkbox"/> Food/Clothing Pantry	<input type="checkbox"/> Nutritionist /WIC	<input type="checkbox"/> Women's Health
<input type="checkbox"/> EFNEP	<input type="checkbox"/> Housing	<input type="checkbox"/> Parenting	<input type="checkbox"/> Women's shelters
<input type="checkbox"/> Employment Assistance	<input type="checkbox"/> HIV care coordination	<input type="checkbox"/> Post Partum Care	
<input type="checkbox"/> Family Planning	<input type="checkbox"/> Immunizations	<input type="checkbox"/> Shelter, Homeless	
<input type="checkbox"/> Financial	<input type="checkbox"/> Infant PMP	<input type="checkbox"/> Smoking Cessation	<input type="checkbox"/> Other

EDUCATION TOPICS/CODES CHECK all that apply			
<input type="checkbox"/> Abstinence	<input type="checkbox"/> Domestic Violence prevent	<input type="checkbox"/> Infant stimulation	<input type="checkbox"/> Parenting
<input type="checkbox"/> Anticipatory guidance	<input checked="" type="checkbox"/> Family Planning	<input type="checkbox"/> Infant feeding	<input checked="" type="checkbox"/> Post Partum care
<input type="checkbox"/> Child Abuse Prevention	<input type="checkbox"/> General Advice	<input checked="" type="checkbox"/> Infant sleep position	<input type="checkbox"/> Safety
<input type="checkbox"/> Breastfeeding	<input type="checkbox"/> Illness care	<input type="checkbox"/> Infant care, general	<input checked="" type="checkbox"/> Secondhand Smoke
<input type="checkbox"/> Community Resources	<input type="checkbox"/> Immunization schedule	<input type="checkbox"/> Injury prevention	<input type="checkbox"/> Smoking Cessation
<input type="checkbox"/> Coping Skills		<input checked="" type="checkbox"/> Newborn care	<input type="checkbox"/> WIC
		<input type="checkbox"/> Nutrition	

TOTAL CARE COORDINATION SERVICES		
Total Care Provided	Initial assessment + 2 reassessments + outcome = 01	Initial assessment + 1 reassessment + outcome = 02
	Initial assessment + outcome = 03	Initial assessment + 1 reassessment = 04
	Initial assessment + 2 reassessments = 05	Initial assessment only = 06

Total Number of Encounters By:	Prenatal Care Coordinator			Community Health Worker		
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